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Royal College of Obstetricians & Gynaecologists

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Professor Norman S Williams
President
President's Office
The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE

Dear Professor Williams

RCOG welcomes the opportunity to contribute to the discussion regarding the impact of the implementation of the Working Time Directive (WTD). We feel the specialty has unique insight into the effects. This stems from the nature of the specialty, which is both a 24-hour emergency discipline (Labour Ward) and an out-patient medical and elective surgical discipline. We fully recognise that the requirement to reduce working hours of staff is driven by the need to ensure staff are fully alert and able to provide high quality patient care. We therefore support the directive to ensure patient (and staff) safety.

The implementation, within the workplace, has necessitated a number of changes that have had consequences to the delivery of service. There is recognition within the discipline that the WTD has been preferentially enforced in relation to trainees as a result of the financial penalties that the service incur if it is breached. The regular monitoring of their rotas has ensured this is high priority. However we do not have evidence that there is a parallel system to ensure that trained staff are monitored, hence there has not been the same imperative to address trained doctor workload.

At the outset it is important to highlight that it is impossible to disentangle the effects of multiple changes on training and education: financial climate, immigration changes, feminisation of medical workforce, rota gaps, implementation of MMC and workforce planning. Hence any data collected cannot distinguish the effect of WTD alone. RCOG believe the consequences of implementation of WTD are:

Time in training

With a 24-hour/7 day a week specialty, new rotas were required to implement WTD (48hour/week) resulting in full shift working. While there was planning around the need for new rotas for trainees, we are unaware of any proactive change to the way in which training was delivered. The effect was that all trainees worked on average 8 hours less per week (previously on 56 hours/week). RCOG training programme is a 7 year programme; hence this reduced their hands on training time by approximately 36 weeks (assuming a 42 working week year). This is a substantial amount of training time. There was no compensatory extension of training to accommodate the effect. All craft specialties highlighted this issue however no changes were made. This has put pressure on trainees acquiring and mastering skills – both in decision-making and procedural skills. While competency is achieved through the current training schemes (as evidenced by gaining CCT), the trainees do not gain as much experience as result of the effect of WTD and this is reflected in their confidence.

Rota redesign

The design of any rota is largely dependent upon the intensity of out of hours (OOHs) work. As a high intensity workload specialty, a full shift pattern was required in most units. The specialty moved from trainees undertaking on call rotas to shift working. This necessitated trainees undertaking a series of nights of shift work. The immediate effect following the introduction of shifts were that there were fewer individuals available during daytime hours to acquire training and provide service. When services are tight, emergency care is staffed first; hence trainees are regularly removed from their training sessions to provide emergency care to the detriment of their own training needs. It is difficult to provide hard evidence of this impact, however we have attempted to measure the effect in two ways.

RCOG subspecialty training, which is undertaken by a small cohort of trainees in the final two years of the programme, is assessed through a process of RCOG external assessors reviewing individual trainees' progress. Surveys of the subspecialty training programme directors show that the rotas have had an effect which has resulted in trainees requiring increased amounts of time to complete the requirements of the programme (Appendix A). This is corroborated by information on individual trainees requiring additional training, extending their CCT date.

Additionally, as part of the GMC National Training Survey, RCOG specialty specific questions show that 40% of trainees (includes O&G ST trainees of all grades) report being removed from training sessions, to cover service, to the detriment of their own training objectives. (Appendix B)

Shift working

In obstetrics and gynaecology, shift working for trainees is the norm. We promote a 4:3 split for night shift working, rather than 7 consecutive nights, for the benefit of staff concentration and therefore patient safety. Additionally, shift working is becoming more common for trained staff as consultants increasingly provide overnight resident working in units across the country. This does benefit both patients and trainees – providing high quality care and trainee supervision.

Team working

The consequences of shift working and the requirement for compensatory rest (built into rotas) is of fragmentation of continuity of patient care and resulting in the need for better handover and team working. However for patients this is confusing, as they would prefer their individual specialist to remain the same throughout their care. It is important that patients are not given unrealistic expectations in relation to their named clinician.

Loss of apprentice style training

Reduced working hours and shift pattern work result in trainees being less "visible" to trained staff. The loss of the vertical consultant team model has resulted in a lack of a feeling of "belonging" for trainees, especially those in the junior tier. Additionally trained staff are less aware of each individual trainees' training needs.

Differential effect on elective gynaecology training

One marked effect of the implementation of WTD is the differential effect on training in obstetrics and gynaecology. The effect of the reduction of hours is more marked in surgical skill acquisition in gynaecology as opposed to obstetrics. This is because of the fact that workload in obstetrics is spread throughout 24-hour day as an emergency specialty – the new rota and shifts still allow trainees significant access to gain clinical skills and experience. Gynaecology, as an elective surgical skill, is largely provided during daytime working hours – the rota changes required to comply WTD have reduced the net daytime training of trainees. This means that it takes longer for trainees to gain elective surgical skills as a result of reduced exposure to surgical workload.

Solutions

Ensuring a safe OOHs is essential. Service and training leads report that in some areas, services have been redesigned to balance rotas. WTD has contributed to this as units struggle to provide OOH cover.

RCOG strongly believe that trained doctors should deliver healthcare. This was the tenet of the changes to medical education following the Calman report. Hence we advocate units consider providing OOHs service with trained staff in resident shifts. This will ensure senior presence and decision-making, benefitting patient care and allows trainees to be released to undertake more supervised daytime training. In larger maternity units, trainees may still be providing OOH as well as the trained doctor however the presence of the consultant improves the quality of training, allowing trainees to gain the most from the experience.

With the reduction in daytime hours that trainees are exposed to, it is important that training is modified to compensate for this. In order to improve trainee skills, it is vital that simulation training assumes a greater role. It allows learning to occur in a safe environment and allows trainees to "practice" before undertaking procedures on patients. Simulation promotes reflective practice by structured constructive feedback. Greater use of feedback for all learning opportunities is necessary especially focusing on non-technical skills and situational awareness as the opportunity for learning through multiple experiences is less for current trainees than their counterparts previously.

Summary

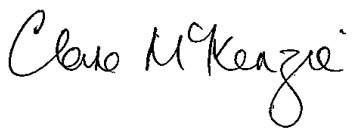
There are a number of issues that have adversely affected training and service provision over recent years it is difficult to isolate a single cause, however the implementation of WTD has had a significant effect. The immediate consequence was a reduction in training time.

RCOG support safe working practices and view WTD as beneficial to patient care. The issues that have arisen as a consequence of WTD surround the fact that modifications to training were not made at the time of implementation (length of training or change of delivery of training). The effects are exacerbated by persistence of "tight" rotas and ongoing reliance on training grade staff to provide the majority of OOH care.

New models for the provision of OOH care are required to be further developed utilising trained staff, which will improve training and patient care. In order to accelerate training, greater use of simulation is required to acquire skills. Additionally RCOG support and are promoting increased quality of feedback in both technical and non-technical skills to allow trainees to maximise each clinical encounter.

RCOG are pleased to support a review of the effect of implementation of WTD and hope this information is useful. We would welcome the opportunity to discuss the issues with the taskforce.

Yours sincerely



Dr Clare McKenzie, FRCOG
RCOG Vice President (Education)

Appendix A

Subspecialty Training and EWTD Questionnaire
Analysis of 2008 and 2009 Responses (Extract)

A questionnaire was sent to all STPSs in 2008 asking for their views regarding the impact of EWTD on subspecialty training. The same questionnaire was sent out one year later to assess whether there had been any change in trainers' views since the introduction of EWTD.

Response Rate:

	GO Gynaecological Oncology	MFM Maternal Fetal Medicine	UG Urogynaecology	RM Reproductive Medicine
2008	**66.7%**	**74%**	**64%**	**38%**
2009	**85%**	**72%**	**69%**	**65%**

The results are based on 64 responses to the questionnaire.

2. What is the frequency of your trainee's on-call rota?

	2008	2009		2008	2009
GO	**Mode 1 in 7**	**1 in 8**	**Range**	**5 – 10**	**7- 10**
MFM	**Mode 1 in 10**	**1 in 8**	**Range**	**6 – 16**	**7 - 11**
UG	**Mode 1 in 9**	**1 in 9**	**Range**	**6 – 10**	**8 - 10**
RM	**Mode 1 in 7**	**1 in 9**	**Range**	**6 – 8**	**7 - 11**

3. Does the on-call rota impact on subspecialty training? – YES

Subspec	Percentage		Number of sessions lost in 6 months		Number of sessions lost in 6 months	
			Mean		Range	
	2008	2009	2008	2009	2008	2009
GO	**72**	**90**	**30**	**37**	**12-48**	**20-60**
MFM	**75**	**90**	**26**	**30**	**6-46**	**10-50**
UG	**80**	**95**	**29**	**40**	**20-48**	**12-100**
RM	**60**	**80**	**25**	**30**	**12-40**	**15-60**

6. Has your trainee's length of clinical training been extended because of on call commitment?

	YES		Length of Extension	
	2008	2009	2008	2009
GO	**22%**	**55%**	**3 mths**	**3-12 mths**
MFM	**40%**	**48%**	**3-6 mths**	**3-12 mths**
UG	**6%**	**33%**		**3-6 mths**
RM	**28%**	**25%**	**3 months**	**3-6 mths**

Appendix B

GMC Trainees Survey, 2013

Specialty Specific Question re: removal from training sessions

Question - In this post, I have been removed from training sessions, to cover service, to the detriment of my own training objectives

Audience – All O&G trainees completing the survey (1897 responses to this question)

Overall: